| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                        |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458 | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | ONSTRUCTION  01   | (X3) DATE SURVEY COMPLETED 06/20/2011 |
|---|--|--|--|---|---------------------------------------|
| NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER |  |  | 9630 F                                     | ADDRESS, CITY, STATE, ZIP CODE<br>IFTH ST<br>AND, IN46322           | •                                     |
| (X4) ID   | SUMMARY S  | STATEMENT OF DEFICIENCIES                                | ID   | PROVIDER'S PLAN OF CORRECTION                                       | (X5)                                  |
| PREFIX  | (EACH DEFICIEN   | ICY MUST BE PERCEDED BY FULL                             | PREFIX                                     | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION                            |
| TAG   | REGULATORY OR  | LSC IDENTIFYING INFORMATION)                             | TAG  | DEFICIENCY)   | DATE                                  |
| K0000   |  |  |  |   |                                       |
|   | A Life Safety C  | ode Recertification                                      | K0000                                      |   |                                       |
|   | and State Licer  | isure Survey was   |  |   |                                       |
|   | conducted by t   | he Indiana State   |  |   |                                       |
|   | Department of  |  |  |   |                                       |
|   | -  | th 42 CFR 483.70(a).                                     |  |   |                                       |
|   | accordance with  | 11 42 C1 K 403.70(a).                                    |  |   |                                       |
|   | Survey Date: 0   | 06/20/11   |  |   |                                       |
|   | Facility Numbo   | r: 000267  |  |   |                                       |
|   | Facility Number: 000367  |  |  |   |                                       |
|   | Provider Numb  |  |  |   |                                       |
|   | AIM Number: 100289280  |  |  |   |                                       |
|   | Surveyor: Bridget Brown, Life  |  |  |   |                                       |
|   | Safety Code Sp   | ecialist   |  |   |                                       |
|   |  | ety Code survey,   |  |   |                                       |
|   | Highland Nurs  |  |  |   |                                       |
|   | Rehabilitation   | Center was found   |  |   |                                       |
|   | not in complia   | nce with   |  |   |                                       |
|   | Requirements   | for Participation in                                     |  |   |                                       |
|   | Medicare/Medi  | icaid, 42 CFR  |  |   |                                       |
|   |  | O(a), Life Safety  |  |   |                                       |
|   | -  | · ·  |  |   |                                       |
|   | from Fire and the 2000 edition of the National Fire Protection       |  |  |   |                                       |
|   |  |  |  |   |                                       |
|   | Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing |  |  |   |                                       |
|   |  |  |  |   |                                       |
|   |  | ccupancies and 410                                       |  |   |                                       |
|   | IAC 16.2.  |  |  |   |                                       |
|   | This one steer   | facility was   |  |   |                                       |
|   | This one story   |  |  |   |                                       |
|   | determined to  | be of Type II (222)                                      |  |   |                                       |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1XZS21

Facility ID:

000367

TITLE

If continuation sheet

|                              |   | X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIPLE CONSTRUCTION |              | NSTRUCTION   | (X3) DATE SURVEY |                    |
|------------------------------|---|--|----------------------------|--------------|--|------------------|--------------------|
|                              |   | IDENTIFICATION NUMBER:   | A. BUILDI                  | ING          | 01   | COMPL            |                    |
| 155458                       |   | 155458   | B. WING                    |              |  | 06/20/2          | 011                |
| NAME OF PROVIDER OR SUPPLIER |   |  |                            |              | DDRESS, CITY, STATE, ZIP CODE  |                  |                    |
| LIICHLAN                     |   |  |                            |              | FTH ST   |                  |                    |
|                              |   | REHABILITATION CENTER  |                            |              | ND, IN46322  |                  |                    |
| (X4) ID                      |   | TATEMENT OF DEFICIENCIES   |                            | ID           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE   |                  | (X5)               |
| PREFIX<br>TAG                | `   | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)   |                            | REFIX<br>TAG | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  |                  | COMPLETION<br>DATE |
|                              | construction ar   | · · · · · · · · · · · · · · · · · · ·  |                            |              |  |                  |                    |
|                              |   | ne facility has a fire   |                            |              |  |                  |                    |
|                              | alarm system w  |  |                            |              |  |                  |                    |
|                              | detection in the  |  |                            |              |  |                  |                    |
|                              |   |  |                            |              |  |                  |                    |
|                              |   | the corridors. The spacity of 38 and   |                            |              |  |                  |                    |
|                              | · ·   | f 32 at the time of  |                            |              |  |                  |                    |
|                              |   | 1 32 at the time of  |                            |              |  |                  |                    |
|                              | this survey.  |  |                            |              |  |                  |                    |
|                              | Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 06/23/11.  The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by: |  |                            |              |  |                  |                    |
|                              |   |  |                            |              |  |                  |                    |
| K0046<br>SS=F                | duration is provided 19.2.9.1.  Based on observeiew and interfailed to provided documentation periodic testing and annual test for 1 of 1 batter emergency light  | erview; the facility le complete test of 30 second g at 30 day intervals ting for 1 1/2 hours lary powered uting fixtures. LSC a functional test cted on every | K004                       | 46           | Preparation and/or execution of this plan not constitute admission or agreement by provider of the truth of the facts alleged conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.  K 046 Emergency Lightning (a) What corrective action(s) be accomplished for those reside found to have been affected by the practice: Facility has inspected the batter back up lightning on the general | will ents        | 07/20/2011         |

000367

|                               |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:       | ľ      | ULTIPLE CO               | NSTRUCTION<br>01   | (X3) DATE SURVEY<br>COMPLETED         |
|-------------------------------|--|--|--------|--------------------------|--|---------------------------------------|
| 1554                          |  | 155458   | B. WIN |                          |  | 06/20/2011                            |
| NAME OF PROMPTED OR GURNI IED |  |  |        | STREET A                 | ADDRESS, CITY, STATE, ZIP CODE   |                                       |
| NAME OF PROVIDER OR SUPPLIER  |  |  |        | 9630 FI                  | FTH ST   |                                       |
|                               | HIGHLAND NURSING AND REHABILITATION CENTER   |  |        | <u> </u>                 | AND, IN46322   |                                       |
| (X4) ID                       |  | STATEMENT OF DEFICIENCIES                                  |        | ID                       | PROVIDER'S PLAN OF CORRECTION  | (X5)                                  |
| PREFIX<br>TAG                 | ` `  | ICY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION) |        | PREFIX<br>TAG            | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | TE COMPLETION DATE                    |
| IAG                           |  | •  | +      | IAG                      | and found it is performing prop  |                                       |
|                               |  | nting system at 30   |        |                          | and the facility Maintenance Di  |                                       |
|                               | I -  | or not less than 30  |        |                          | ment   |                                       |
|                               |  | n annual test shall  |        |                          | monthly and annually according   |                                       |
|                               | be conducted f   | or not less than 1   |        |                          | code.  |                                       |
|                               | 1/2 hours. Wr  | itten records of   |        |                          |  |                                       |
|                               | visual inspection  | ons and tests shall  |        |                          | (b) How you will identify of   | • • • • • • • • • • • • • • • • • • • |
|                               | be kept. NFPA  | . 110, 5-3-1 requires                                      |        |                          | residents having potential to b<br>affected by the same practice                       |                                       |
|                               | battery powered  | lighting at the emergency                                  |        |                          | what corrective action will be   |                                       |
|                               | generator. This  | deficient practice   |        |                          | taken:   |                                       |
|                               | could affect all   | occupants.   |        |                          | Any resident has the potential to  | • • • • • • • • • • • • • • • • • • • |
|                               |  |  |        |                          | affected but none were identifie   | ed.                                   |
|                               | Findings include:  Based on review of the Weekly   |  |        |                          | (c) What measures will be p  | nt                                    |
|                               |  |  |        |                          | into place or what systematic  | ut                                    |
|                               |  |  |        |                          | changes you will make to ensu  | re                                    |
|                               |  | •  |        |                          | that the practice does not recu  | r:                                    |
|                               | Generator Syst   |  |        |                          | у  |                                       |
|                               | Testing records which included a   |  |        |                          | hly  |                                       |
|                               | check of the exterior emergency  |  |        |                          | and a 90 min annually. All emergency lighting will be                                  |                                       |
|                               | _  | r the generator with                                       |        |                          | checked on the monthly Perform   | mance                                 |
|                               | the maintenand   |  |        |                          | Maintenance Program, (PM).   |                                       |
|                               |  | :25 p.m., the record                                       |        |                          | The maintenance director will e  | ensure                                |
|                               | was blank for e  | emergency light  |        |                          | the PM on the emergency lights   | s is                                  |
|                               | testing since M  | Iarch 2011 when  |        |                          | performed  |                                       |
|                               | the last annual  | and monthly  |        |                          | (d) How the corrective actio   | m(s)                                  |
|                               | emergency ligh   | nt test was  |        |                          | will be monitored to ensure th   | ` '                                   |
|                               | documented. The maintenance director said at the time of review, the he had forgotten to record the test although he did it routinely. |  |        |                          | practice will not recur, i.e., wh  |                                       |
|                               |  |  |        |                          | quality assurance program wi   | • • • • • • • • • • • • • • • • • • • |
|                               |  |  |        |                          | put into place:  |                                       |
|                               |  |  |        |                          | The monitoring of this will be a   | 2                                     |
|                               |  |  |        |                          | effort between the NHA/ Plant<br>Manager will check all                                | Ops                                   |
|                               | 3.1-19(b)  |  |        |                          | documentation of emergency ba  | ackup                                 |
|                               |  |  |        |                          | lights for the generator to make   | -                                     |
|                               |  |  |        |                          | facility is in compliance and dis  | • • • • • • • • • • • • • • • • • • • |
|                               |  |  |        |                          | these findings at the monthly R  | isk                                   |
|                               |  |  |        | management/QA meeting to |  |                                       |

| INTELLEMENT OF CORRECTION  INTELLEMENT OF PROVIDER OR SUPPLIER  HIGHLAND NURSING AND REHABILITATION CENTER  INTELLEMENT OF DEPICIPACIES  (A4) ID SIMMARY STATEMENT OF DEPICIPACIES (EACH DEPICIENCY MIST BE PERCEDED BY PULL TAG  REGULATORY OR ISC IDENTIFYING INFORMATION)  REGULATORY OR ISC IDENTIFYING INFORMATION  RECULATORY OR ISC IDENTIFYING INFORMATION  REGULATORY OR | STATEMENT OF DEFICIENCIES    |  | X1) PROVIDER/SUPPLIER/CLIA              | (X2) MULTIPLE CONSTRUCTION (X |        | (X3) DATE  | X3) DATE SURVEY        |            |  |
|--|------------------------------|--|---|-------------------------------|--------|--|------------------------|------------|--|
| NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER HIGHLAND NURSING AND REHABILITATION CENTER TAG  SIMMARY STATIMENT OF DEPICEINCES TAG  RECOLLATORY OR I SCHIDENTERVING INFORMATION)  REPERIX TAG  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 110, the Standard for Energency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1 (a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS(Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes.  NFPA 99, 3-5-4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly by the practice. The generator produce this on request. The current Generator optimized and severiced under operating conditions or not less than 30 percent of the EPS(Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes.  NFPA 99, 3-5-4.2 requires a written record of inspection, performance, exercising period and repairs shall be required to the correctly conclude the found to this performance and the least of the correctly conflicted to the found with a focus on the load % testing.  (X3)  STREET ADDRESS.CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN46322  (X3)  REPERIX TAG  SEMETH ADDRESS.CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN46322  (X3)  Complete to complete december of the completation of operations and coverage propriets and completation of the propriets and completation of the propriets and complete  | AND PLAN OF CORRECTION       |  | A. BUILDING                             |                               | DING   | 01   | COMPL                  | COMPLETED  |  |
| NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER  INCHIAND NURSING AND REHABILITATION OF DEFICIENCES  PREFIX  TAG  INCHIAND NURSING AND REHABILITATION  PREFIX  TAG  INCHIAND NURSING AND REHABILITATION  REGULATORY OR ISCUMENTALY  REGUL |                              |  |   |                               |        | <del></del>  |                        | 06/20/2011 |  |
| SAME OF PROVIDER OR SUPPLIES   9630 FIFTH ST   HIGHLAND NURSING AND REHABILITATION CENTER  |                              |  |   |                               |        | ADDRESS, CITY, STATE, ZIP CODE   |                        |            |  |
| HIGHLAND NURSING AND REHABILITATION CENTER  MIGHLAND, IN46322  SUMMARY STATEMENT OF DISTICUNCIES (IACATED DESCRIPTION MIST THE PRESENT DEED THE PULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.1.1. Based on interview and record review, the facility failed to provide complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS(Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regulately by the processor of Plant Ops when he performs his Quarterly systems reviews is recommended.  (c) Date of compliance: 7/20/11  (c) Date of compliance: 7/20/11  (c) Date of compliance: 7/20/11  (d) Date of compliance: 7/20/11  (e) Date of compliance: 7/20/11  (f) Date of compliance: 7/20/11  (c) Date of compliance: 7/20/11  (e) Date of compliance: 7/20/11  (f) Date of compliance: 7/20/11  (f) Date of compliance: 7/20/11  (g) Date of compliance: 7/20/11  (h) Date of compliance: 7/20/11  (g) Date of compliance: 7/20/11  (g) Date of compliance: 7/20/11  (h) Date of compliance: 7/20/11  (p) Date of complian | NAME OF PROVIDER OR SUPPLIER |  |   |                               |        |  |                        |            |  |
| REGULATORY OR LISC IDENTIFYING INFORMATION)  KO144  SS=C  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.  Based on interview and record review, the facility failed to provide complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS(Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and remains shall be regulative.   | HIGHLAN                      | ND NURSING AND   | REHABILITATION CENTER                   |                               |        |  |                        |            |  |
| TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  KO144  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99, 3.4.4.1.  Based on interview and record review, the facility failed to provide complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1 (a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS(Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and remains shall be regulative.  | (X4) ID                      | SUMMARY S  | TATEMENT OF DEFICIENCIES                |                               | ID     | PROVIDER'S PLAN OF CORRECTION  |                        | (X5)       |  |
| determine that compliance has been maintained and oversight by Regional Director of Plant Ops when he performs his Quarterly systems reviews is recommended.  (e) Date of compliance: 7/20/11    Compliance: 7/20/11   | PREFIX                       | (EACH DEFICIEN   | CY MUST BE PERCEDED BY FULL             |                               | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE                     | COMPLETION |  |
| K0144 SS=C  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3,4,4,1.  Based on interview and record review, the facility failed to provide complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7,9,2,3 and NFPA 99, Health Care Facilities, 3,4,4,1,1 (a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6,4,2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS(Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5,4,2 requires a written record of inspection, performance, exercising period and remains shall be requilarly.  | TAG                          | REGULATORY OR  | LSC IDENTIFYING INFORMATION)            | ļ                             | TAG    | DEFICIENCY)  |                        | DATE       |  |
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| K0144 SS=C  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on interview and record review, the facility failed to provide complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS(Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly.   |                              |  |   |                               |        | (e) Date of compliance: 7/2.   | 0/11                   |            |  |
| exercised under load for 30 minutes per month in accordance with NFPA 99.  3.4.4.1.  Based on interview and record review, the facility failed to provide complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS(Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly.   | K0144                        | Generators are ins   | spected weekly and                      | İ                             |        | (c) Bute of compliance. 7/2  | 0,11                   |            |  |
| month in accordance with NFPA 99.  3.4.4.1.  Based on interview and record review, the facility failed to provide complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS(Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly.   |                              |  | · ·                                     |                               |        |  |                        |            |  |
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| admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. K 144  Facilities, 3–4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6–4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS(Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3–5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be requilarly.   |                              | Based on interv  | riew and record                         | K(                            | 144    |  | n of                   | 07/20/2011 |  |
| provide complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS(Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be requilarly  provider of the fruth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. K 144 Generators (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: The generator vendor has been contacted to come out and instruct the Maintenance Director on how to correctly calculate the % of load and to leave a copy of the calculation formula with the maintenance director so that he can produce this on request. The current Generator log form has been reviewed in detail with the maintenance director by the Regional Director of Plant Ops as to how the form should be correctly completed/filled out with a focus on the load % testing. (b) How you will identify other  |                              | review, the faci   | lity failed to                          |                               |        |  | ho                     |            |  |
| for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS(Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and reagirs shall be regularly  alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. K 144 Generators load percentage:(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:The generator vendor has been contacted to come out and instruct the Maintenance Director on how to correctly calculate the % of load and to leave a copy of the calculation formula with the maintenance director so that he can produce this on request. The current Generators load percentage:(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:The generator vendor has been contacted to come out and instruct the Maintenance Director on how to correctly calculate the % of load and to leave a copy of the calculation formula with the maintenance director so that he can produce this on request. The current Generators load percentage:(a) What corrective action(s) will be recause required. K 144 Generators load percentage:(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:The generator on how to correctly calculate the % of load and to leave a copy of the calculation formula with the maintenance director so that he can produce this on request. The current Generator log form |                              | provide compl  | ete documentation                       |                               |        |  |                        |            |  |
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| Facilities, 3–4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6–4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS(Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3–5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly  Generators load percentage:(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:The generator vendor has been contacted to come out and instruct the Maintenance Director on how to correctly calculate the % of load and to leave a copy of the calculation formula with the maintenance director so that he can produce this on request. The current Generator log form has been reviewed in detail with the maintenance director by the Regional Director of Plant Ops as to how the form should be correctly completed/filled out with a focus on the load % testing. (b) How you will identify other  |                              |  |   |                               | 1      | olely  |                        |            |  |
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| EPS(Emergency Power Supply)  nameplate rating at least monthly, for a minimum of 30 minutes.  NFPA 99, 3–5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly  Generator log form has been reviewed in detail with the maintenance director by the Regional Director of Plant Ops as to how the form should be correctly completed/filled out with a focus on the load % testing.  (b) How you will identify other   |                              | •  |   |                               |        | •  | on request.The current |            |  |
| for a minimum of 30 minutes.  NFPA 99, 3–5.4.2 requires a  written record of inspection,  performance, exercising period  and repairs shall be regularly  maintenance director by the Regional Director of Plant Ops as to how the form should be correctly completed/filled out with a focus on the load % testing.  (b) How you will identify other  |                              | EPS(Emergency  | Power Supply)                           |                               |        | • · · · · · · · · · · · · · · · · · · ·                                |                        |            |  |
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| NFPA 99, 3-5.4.2 requires a  written record of inspection,  performance, exercising period  and repairs shall be regularly  to how the form should be  correctly completed/filled out with  a focus on the load % testing.  (b) How you will identify other  |                              | for a minimum  | of 30 minutes.                          |                               |        | 1  |                        |            |  |
| written record of inspection,  performance, exercising period  and repairs shall be regularly  written record of inspection,  correctly completed/filled out with  a focus on the load % testing.  (b) How you will identify other   |                              | NFPA 99. 3-5.4   | .2 requires a                           |                               |        |  | ps as                  |            |  |
| performance, exercising period a focus on the load % testing.  (b) How you will identify other   |                              |  | •                                       |                               |        | 1  | with                   |            |  |
| and repairs shall be regularly (b) How you will identify other   |                              |  | · · · · · · · · · · · · · · · · · · ·   |                               |        |  |                        |            |  |
| I and repairs shall be recollarly  |                              | =  | - · · · · · · · · · · · · · · · · · · · |                               |        |  | -                      |            |  |
|  |                              | and repairs sha  | iii be regulariy                        |                               |        | 1  |                        |            |  |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |  | (X2) M   | ULTIPLE CO | NSTRUCTION   | (X3) DATE S   |           |            |
|--|--|--|------------|--|---|-----------|------------|
| <b> </b>   |  |  |            | LDING  | 01  | COMPLETED |            |
|  | 155458   |  | B. WIN     | IG   |   | 06/20/20  | 011        |
| NAME OF PROVIDER OR SUPPLIER                         |  |  |            | STREET A   | ADDRESS, CITY, STATE, ZIP CODE  | •         |            |
| NAME OF PROVIDER OR SUPPLIER                         |  |  |            | 9630 FI  | FTH ST  |           |            |
| HIGHLAND NURSING AND REHABILITATION CENTER           |  |  |            | HIGHLA   | AND, IN46322  |           |            |
| (X4) ID  | SUMMARY STATEMENT OF DEFICIENCIES                                      |  |            | ID   | PROVIDER'S PLAN OF CORRECTION   |           | (X5)       |
| PREFIX   | (EACH DEFICIENCY MUST BE PERCEDED BY FULL                              |  |            | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT | TΕ        | COMPLETION |
| TAG  | REGULATORY OR LSC IDENTIFYING INFORMATION)                             |  | _          | TAG  | DEFICIENCY)   |           | DATE       |
|  | maintained and   | d available for  |            |  | be affected by the same   |           |            |
|  | inspection by t  | he authority having  |            | practice and what corrective action will be taken: Any |   |           |            |
|  | jurisdiction. T  | · · · · · · · · · · · · · · · · · · ·  |            |  |   |           |            |
|  | practice affects   |  |            |  | resident residing in the facilit<br>the potential to be affected b      |           |            |
|  |  | an occupants.  |            |  | none were identified. (c) Wh  |           |            |
|  |  |  |            |  | measures will be put into p   |           |            |
|  | Findings includ  | le:  |            |  | or what systematic changes  |           |            |
|  | Based on review of the Weekly  |  |            | you will make to ensure that                           |   |           |            |
|  |  |  |            |  | the practice does not recur   |           |            |
|  | Generator Syst   | em Service &   |            |  | The maintenance director wi   |           |            |
|  | · ·  | s provided by the  |            |  | used the generator form to  |           |            |
|  | maintenance director on 06/20/11 at 1:25 p.m., the records included    |  |            |  | complete documentation of le  |           |            |
|  |  |  |            |  | test % monthly as he has be   |           |            |
|  |  |  |            |  | educated. The NHA administ  |           |            |
|  | · ·  | onthly load testing of the   |            |  | will review his monthly finding along with the Regional Direction.      | - 1       |            |
|  | emergency generator. The record  |  |            | of Plant Ops who will review                           |   |           |            |
|  | left blank the r   | eft blank the run time and percent pad for the testing. The naintenance director said at the |            |  | during his quarterly visits. (d)  |           |            |
|  | load for the tes   |  |            |  | How the corrective action(s   |           |            |
|  |  |  |            |  | will be monitored to ensure   |           |            |
|  | time of record review, the load  |  |            |  | practice will not recur, i.e.,  |           |            |
|  |  |  |            |  | what quality assurance  |           |            |
|  | carried during the load test was no more than "about 18 percent", less |  |            | program will be put into pla                           | ice:  |           |            |
|  |  |  |            | Monthly generator load test of                         |   |           |            |
|  | than the 30 percent minimum load                                       |  |            |  | documentation will be review  |           |            |
|  | required. He s   | aid no load bank   |            |  | by the NHA and the Regiona  |           |            |
|  | testing had bee  | en done.   |            |  | Director of Plant Ops for the   | _         |            |
|  |  |  |            |  | 3 months and quarterly there<br>by the regional Director of Pl          |           |            |
|  | 3.1-19(b)  |  |            |  | Ops – to assure that the form   |           |            |
|  | J.1-19(b)  |  |            |  | been completed and calculate  |           |            |
|  |  |  |            |  | correctly. All reports will be  |           |            |
|  |  |  |            |  | submitted to the regional offi  |           |            |
|  |  |  |            |  | for review. Any issues identi   |           |            |
|  |  |  |            |  | will be reported at the next R  |           |            |
|  |  |  |            |  | Management/QA meeting to  |           |            |
|  |  |  |            |  | determine compliance. (e) <b>C</b>                                      | vate      |            |
|  |  |  |            |  | of compliance: 7/20/11IDR request:                                      |           |            |
|  |  |  |            |  | We respectfully disagree with the                                       | ne        |            |
|  |  |  |            | o respectivity disugree with the                       |   |           |            |

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155458 |                | A. BUILDING 01 COMPLETE   |   | (X3) DATE SURVI<br>COMPLETED<br>06/20/2011   |  |                          |  |  |
|---|----------------|---|---|--|--|--------------------------|--|--|
| NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER                                     |                |   | STREET ADDRESS, CITY, STATE, ZIP CODE  9630 FIFTH ST  HIGHLAND, IN46322 |  |  |                          |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)  statement of deficiency:   | D BE COM   | (X5)<br>MPLETION<br>DATE |  |  |
|   |                |   |   | Per NFPA 110 8.4.9.5.1 20 edition:  "For diesel-powered EPS, shall be not less that 30 pethe nameplate kW rating of A supplemental load bank permitted to be used to meet or exceed percent requirement."  Our facility utilizes gas-powered EPS and con is not subject to loading indicated a | loading ercent of f the EPS. shall be the 30 s a natural sequently |                          |  |  |